influence the findings of a cognitive deficit and a diagnosis of organic brain damage.

I personally feel that neuropsychological testings must be used only as an adjunct along with extensive neurologic tests including computed tomographic scans, electroencephalograms and evoked action potential testings. The use of neuropsychological testing alone can lead to an "overdiagnosis."

The Medical Advisory Committee of the California Division of Industrial Accidents has stated that neuropsychological tests to determine organic brain damage are not to be used as a sole basis for the diagnosis in such cases. Clinical features and other test results must be factors.

Admittedly, better and more sensitive testing is needed but I do not feel, as the authors apparently do, that the answer is neuropsychological testing only.

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AIDS Transmission

TO THE EDITOR: H. Hunter Handsfield's article in the October 1985 issue, "Decreasing Incidence of Gonorrhea in Homosexually Active Men—Minimal Effect on Risk of AIDS,"[1] may need further clarification.

(1) Gonorrhea versus acquired immunodeficiency syndrome (AIDS) incidence: If the average incubation period for sexual inoculation to CDC-defined AIDS is around five years as in blood transfusion associated AIDS,[2] one would assume that most persons diagnosed as having AIDS in 1985 were inoculated before late 1982. At that time, gonorrhea rates began to fall rapidly in San Francisco concurrent with the issuing of "safe sex" guidelines. The only way to assess the efficacy of "safe sex" guidelines for AIDS is to study the sexual practices of those who have recently seroconverted with respect to HTLV-III/LAV/ARV antibody. A study in San Francisco has shown that all recent seroconverters have participated in sexual activities that resulted in the exchange of semen and other body fluids.[3]

(2) Monogamy: Exchange of body fluids—that is, "unsafe sex," may be safe only to those who have been in bilateral monogamous relationships, or celibate, since around 1978, when seropositivity to LAV was first noted in homosexual men in San Francisco.[3,4] Those who have become monogamous more recently should be counseled to follow "safe sex" guidelines since a long-term carrier state has been described with AIDS.

(3) Sexual practices may be classified according to the San Francisco AIDS Foundation and Bay Area Physicians for Human Rights as "safe" (mutual masturbation, massage, hugging and dry kissing), "possibly safe" (fellatio interruptus, cunnilingus, vaginal or rectal intercourse with condom and wet kissing) and "unsafe" (vaginal or rectal intercourse without condom, receiving ejaculate in mouth and oral- or manual-anal contact).

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3. Echenberg D, Rutherford G, O'Malley P, et al: Update: Acquired immunodeficiency syndrome in the San Francisco Cohort Study, 1978-1985. MMWR 1985; 34:573-575

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Correction—Hepatitis A

TO THE EDITOR: The Epitomes of Occupational Medicine (October 1985) provided a well-rounded update of this complex field. There is a gross error, however, in the section on the health of refugees and employment.[1] Dr Felton states that hepatitis B in a food handler presents a public health risk. I would like to believe this is a typographical error, intended to state hepatitis A; but in my practice of public health I find numerous physicians who fail to differentiate the two extremely different diseases. Also, for the sake of completeness, other occupations and settings are considered at high-risk when fecal-oral diseases are present in a worker or service recipient: medical-care providers, day-care workers or day-care attendees. Finally, there is no report in the literature known to me of *Entamoeba histolytica* being spread by contaminated food, which is not to say that it hasn't or couldn't happen. Chronic salmonellosis, particularly typhoid, should not be forgotten.

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EDITOR'S NOTE

Dr Dassey is correct. Hepatitis A was intended and the error was a typographical one.

MSMW